Health Regulation Administration

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0030				A. BUILDII	· · · · · · · · · · · · · · · · · · ·		(X3) DATE SURVEY COMPLETED		
		B. WIŅG		02/2	02/20/2007				
NAME OF P	MTS 809 49TH				DDRESS, CITY, STATE, ZIP CODE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SCIDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETE DATE		
	13, 2006, however, survey could not be 2006. The population comprised of four form of mental retardation were identified for the survey were based with residents and serview of resident as including incident resident as including incident residents and serview of resident as including incident residents.  Thus Statute is not Surveyor: 17929  Based on observatificated to maintain the GHMRP in a in a sea and sanitary manner. The findings include The environmental conducted on February were identificated.	ey was initiated on Findue to inclement we completed until Febon of the facility was emales with varying on. A random samplimis survey. The findion observations, intestaff in the home, as and administrative resports.  EPING  maintenance equipm, properly maintained unction for which it is met as evidenced by ons and interview, the interior and exterior fie, clean, orderly, at it.	eather, the pruary 20, degrees ag of two ings of the erviews well as a cords, ment shall d and is to be crossed to be many or of the tractive, MRP was ollowing as not	I 000	1. The upstairs bathroom flooff by4-15-07.	CETVED ENT OF HEALTH REGULATION NISTRATION	ed		
; } ,	2. The water in the								
	ation Administration  A A A A A A A A A A A A A A A A A A A	ER/SUPPLIER REPRESEN	ITATIVE'S SIG	NATURE	eiector of Residential	Denices	(X6) DATE 3-14-07		

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Health Re	egulation Administra	ition		<del></del>	<del> </del>			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER HFD12-0030			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/20/2007			
MAME OF P	POWDER OR SUPPLIER	11 D 12-0030	STREET ADD	PRESS, CITY,	STATE, ZIP CODE	,		
809 49TH			•					
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS- COMPLETE		
-	Continued From page 1 continuously in the upstairs bathroom.  3. The dresser in Resident #3's bedroom had a missing knob.  4. The caulking around the tub in the upstairs bathroom was dirty and needed to be replaced.			091	<ol> <li>The toilet will be repaired</li> <li>Resident #3's dresser knot by3-28-07.</li> <li>The upstairs tub caulking wby3-30-07</li> </ol>	will be replaced		
48.   135   NA.    W	Each GHMRP shart conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.		fire drills in	l 135	The facility manager conducts we audits and reports findings to the for follow up3-21-07.	ekly environmental residential director		
	Surveyor: 17929 A review of the fire February 20, 2007 concerns were ide  1. During the monand September 20 drills conducted.  2. During the monand September 20 drills conducted.	ths of July 2006, Aug 106, there was no we ths of January 2007, 206, there was no dr 3:00 a.m. to 4:00 p.m	cted on ollowing gust 2006, ekend February ill n. shift.	·	The home will conduct weekly fir 12, 2007 through April 30, 2007 all shifts conduct at least one fire period. The facility manager will for the period that insures that at I conducted by each shift, including weekend overnight. In addition the staff on properly conducting a drill fire drill form3-30-07  The remaining schedule of 2007 winsure that each shift has a drill at quarterly3-30-07.	in order to insure that drill during the develop a schedule east one drill is weekend day and e QMRP will train I and completing the ill be modified to minimum		
	2006 and July 28, therefore it could rethe drill was conducted. 3509.6 PERSONN Each employee, personnually thereafte		nd sician 's	I 206	The QMRP will report the status of routine meetings with the resident 07.  All of the cited health certificates or are being obtained at present. A by3-30-07	al director3-30-		

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MODES PLAN OF CORRECTION IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		HFD12-0030		B. WING	)	02/20/2007	
MAME OF PROVIDER OR SUPPLIER MTS			STREET ADDRESS, CITY, STATE, ZIP CODE  809 49TH ST, NE WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	JLD BE CROSS COMPL	
1 206	6 Continued From page 2 performed and that the employee's health state would allow him or her to perform the required		th status uired	1206	MTS is developing an office-base personnel information that will in track needed documents and also against home file deficiencies3	nprove its ability to provide a "fail safe"	
7 1 14 1	Surveyor: 17929 Based on review of ensure each emplo	i met as evidenced by: f records, the GHMRP byee had a current phys	sician's				
	certification that in- been performed ar	dicated a health inventorid documented the conduction allow him/her to prefore	ory had sultants				
	Review of the pers 2007, at 12:00 p.m failed to provide ph	onnel files on February  reflected that the GHI ysician's certification fo ty's professional staff/ ologist; ter and	MRP				
	Each GHMRP shall professional staff to necessary professional accordance with the individual habilitation professional service limited to, those se	I have available qualified carry out and monitor onal interventions, in e goals and objectives on plan, as determined attendisciplinary team. The may include, but not rvices provided by indiv	of every to be	l 391			
Ith Regula TE FORM	tion Administration		669	9	BQPN11	If continuation sheet	

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Health Re	gulation Administra	ation		-T			
STATEMENT OF DEFICIENCIES (X-AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		HFD12-0030		B. WING		02/20/2007	
NAME OF PR	OVIDER OR SUPPLIER	<u> </u>	STREET ADD	RESS, CITY,	STATE, ZIP CODE		
мтѕ			809 49TH WASHING	ST, NE TON, DC 2	0019		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS- COMPLETE	
<u>.u</u> .		and licensed as requi	red by	l 391	The PCP and psychiatrist licenses wiby3-28-07.	ll be in place	
Fic ST ,A":	(a) Medicine; This Statute is not met as evidenced by: Surveyor: 17929 The GHMRP failed to have evidence of curent licensure for its Primary Care Physician and Psychiatrist.						
I <b>3</b> 99	3520.2(i) PROFES PROVISIONS	SSION SERVICES: G	SENERAL	I 399			
	professional staff the necessary professional sacordance with the individual habilitation necessary by the inprofessional service limited to, those settrained, qualified, and the necessary by the inprofessional service limited to, those settrained, qualified, and the necessary professional services are necessary professional services.	If have available qual to carry out and monitional interventions, in the goals and objective on plan, as determinaterdisciplinary teamores may include, but ervices provided by in and licensed as requited law in the following of services:	itor n es of every ed to be . The not be ndividuals ired by				
	(i) Speech and la	anguage therapy; and	d	j	·		
:	Surveyor: 17929 The GHMRP faile	t met as evidenced to d to have evidence o tion for its Speech a ist	f current		The speech pathologist license will b by3-28-07.	e obtained	
1 436	3521.7(f) HABILI7	ATION AND TRAIN	ING	1 436		! !	
		nd training of residen ude, when appropria				, ,	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-9030		(X2) MULTIFLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/20/2007			
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE				
809 49TH									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETE DATE		
1 436	use and self-adminaid, care and use of devices, preventive devices, preventive and preventive devices, pre	following areas: fuding skills related to sistration of medication of prosthetic and orth the health care, and sa met as evidenced by tion, interview and re- provide se in accordance to the sin the sample (Clie	on, first otic fety); y: cord elf- e ability's nt's #1  tion on lity's LPN or Client cup for area the em ('s ISP at the rashing Facility's ed to a level own  tion on se was	I 436	Nursing will re-assess the self modient #1, obtain an accurate ass skill levels and growth potential medication training program ain	essment of her cur and initiate a self	rent L		
ealth Requ	Client #1 came to the medication area with a cup of water. Client #2 accepted the medications from the nurse and took them without assistance.				skills to the highest level possil assist nursing in this task3-30	ole. The QMRP ill	:		

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  HFD12-0030  STREET ADDRESS, CITY, STATE, ZIP CODE  809 49TH ST, NE  WASHINGTON, DC 20019  (X4) ID FREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  1 436  COMPLET  (X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  1 436  Continued From page 5	Health Regulation Administration								
STREET ADDRESS, CITY, STATE, ZIP CODE 809 49TH ST, NE WASHINGTON, DC 20019  [ACA) ED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1 436 Continued From page 5  Review of Client #1's ISP dated 9-11-06, she is capable of feeding herself, washing clothing and dishes. Interview with the Facility's Registered nurse acknowledged the need to reassess the client's self medication skills the client is trained at a level that meets her ability to administer her own medications.	(X3) DATE SURVEY COMPLETED 02/20/2007								
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